Complete Summary

GUIDELINE TITLE

The assessment and management of people at risk of suicide.

BIBLIOGRAPHIC SOURCE(S)

New Zealand Guidelines Group (NZGG). The assessment and management of people at risk of suicide. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 May. 72 p. [89 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Self harm or attempted suicide

GUIDELINE CATEGORY

Counseling
Management
Prevention
Risk Assessment
Treatment

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Internal Medicine
Preventive Medicine
Psychiatry

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Emergency Medical Technicians/Paramedics
Health Care Providers
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

To guide those working in emergency departments and in acute psychiatric services in the appropriate assessment and early management of suicidal people

TARGET POPULATION

Children, adolescents, adults, and elderly persons in New Zealand who self harm or attempt suicide or are at-risk for suicide

INTERVENTIONS AND PRACTICES CONSIDERED

Prevention/Risk Assessment

1. Identification and assessment of risk factors
    - Presence of concomitant mental illness
    - Information from relatives, friends
2. Screening using the Beck Hopelessness Scale
3. Specialised assessments:
    - chronically suicidal people
    - intoxicated people
4. Comprehensive psychiatric/psychosocial assessment

Treatment/Management

1. Establishment of a therapeutic alliance
    - Involvement of family, whanau, and other support people
    - Provision of age and culturally appropriate services (e.g. language interpreter)
    - Patient confidentiality and consent
2. Triage and RAPID Assessment tools
3. Specialised staff training
    - Clinical case note taking and structured assessments
    - Provision of counseling services for staff

4. Medication, including:
    - haloperidol
    - benzodiazepine
    - lorazepam
    - clonazepam
5. Referral to mental health services
6. Outpatient Management
    - Use of a "Safety contract" and/or "Green card" (24-hour access to a crisis team) are considered but not specifically recommended.
7. Hospitalization and inpatient management
    - Levels of observation (e.g., within reach; same room and in sight; frequent observations)
8. Discharge planning
    - Patient/care provider education including
        - Medication use
        - Follow up care
        - "Safe home" environment
9. Management of chronically suicidal people

MAJOR OUTCOMES CONSIDERED

- Repeat presentations for suicidality
- Repeat suicide attempts
- Mortality from suicide

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic literature review was prepared by the New Zealand Health Technology Assessment (NZHTA)

A systematic method of literature searching and selection was employed in the preparation of this review. Searches were limited to English language material published from 1990 onwards. The searches were completed in April 2002 using bibliographic databases (MEDLINE, EMBASE, CINAHL, PsychINFO, Current Contents, Science/Social Science Citation, Index New Zealand) and review databases (Evidence-based medicine reviews, Cochrane Database of Systematic Reviews, DARE, NHS Economic Evaluation Database, Health Technology Assessment Database). Hand searching of journals or contacting of authors for unpublished research was not undertaken during the search process.

Study Design and Sample Size:

- Studies employing one of the following designs: systematic review or meta-analysis, randomised controlled trials, cohort study, case-control study
- Studies contained samples of at least six participants.

Study Exclusion Criteria

The following criteria were used to exclude studies from appraisal:

- study population concerned:
    - primarily (50% or more) children 12 years of age and under
    - homicidal people
    - criminal offenders
- studies concerned with:
    - the treatment of people with drug/substance abuse or dependence (that is, treatment directed to their addiction rather than any suicide attempt)
    - suicide prevention interventions specifically for people with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS)
    - school-based suicide prevention interventions
    - economic analysis
- studies involving small numbers of case presentations (five or fewer cases)
- studies not clearly describing their methods and results or having significant discrepancies
- citations which were letters to the editor, comments, editorials, abstract only, or conference proceedings

Search Terms Used

MEDLINE subject terms (Medical Subject Heading [MeSH] terms): suicide, suicide attempted, exp self-injurious behavior, crisis intervention, emergencies, emergency treatment, exp antipsychotic agents, exp psychotropic drugs, exp antidepressive agents, exp tranquilising agents, psychopharmacology

PsychINFO subject terms: suicide, self-destructive behavior, attempted suicide, suicidal ideation, suicide prevention, self-inflicted wounds, self-mutilation, side-effects drug, risk factors, risk analysis, exp drugs, drug therapy

Additional keywords: suicid*, parasuicid*, crisis, crises, psychopharm*.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1++

High quality meta-analyses/systematic reviews of randomised controlled clinical trials (RCTs), or RCTs with a very low risk of bias

1+

Well-conducted meta-analyses/systematic reviews, or RCTs with a low risk of bias

1-

Meta-analyses/systematic reviews, or RCTs with a high risk of bias

2++

High quality systematic reviews of case-control or cohort studies

High quality case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+

Well-conducted case-control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-

Case-control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3

Non-analytic studies (e.g., case reports). Case series

4

Expert opinion

Qualitative material was systematically appraised for quality, but was not ascribed a level of evidence.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic literature review including evidence tables were prepared by the New Zealand Health Technology Assessment (NZHTA)

Articles were formally appraised using the checklist schedules and hierarchy of evidence coding system developed by the Scottish Intercollegiate Guidelines Network (SIGN). Validated criteria were used to appraise the studies selected for review. Key facets of the selected studies (including limitations) were documented in the text. Conclusions were drawn based on the study design and the specific problems associated with individual studies. The evidence presented in the selected studies were assessed and classified according to the SIGN grades of guideline recommendation by the suicide prevention guideline group.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendations

A

At least one meta-analysis, systematic review, or randomised, controlled clinical trial (RCT) rated 1++ and directly applicable to the target population

or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B

A body of evidence consisting principally of studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results

or

Extrapolated evidence from studies rated as 1++, or 1+

C

A body of evidence consisting principally of studies rated as 2+, directly applicable to the target population, and demonstrating overall consistency of results

or

Extrapolated evidence from studies rated as 2++

D

Evidence level 3 or 4

or

Extrapolated evidence from studies rated as 2+

Additionally, Good Practice Points are recommended as the best practice based on the clinical experience of the guideline development team.

COST ANALYSIS

Cost-Benefit Issues

Suicide and attempted suicide have both direct and indirect costs to the individual, their family and friends, and to society as a whole. These direct costs include notions of years of life lost, years of living with physical consequences of a serious attempt, and the costs associated with caring for a suicidal person. Indirect costs include quality of life issues for both the individual and their social context: pain, suffering, grief, and the resultant impacts on friends and family in terms of their care requirements. No data exists that quantifies these costs within the New Zealand context, which in turn makes it difficult to estimate costs for implementing these guidelines. It is also difficult to predict savings on the basis of measured outcomes as suicide is a low probability event and it is difficult to determine whether a reduction in deaths from suicide can be attributed to prevention attempts or other wider societal factors.

Implementation of these guidelines will not be cost neutral. If these guidelines are implemented effectively, flow-on costs will include paying staff to attend education and training, supervision costs, costs associated with district health boards (DHBs) working to develop better policies and protocols to enhance interservice co-operation, and costs resulting from audit procedures to ensure that the crisis interventions occur in accordance with best practice. However, we can make assumptions that savings will come from reductions in repeat attempts and better therapeutic engagement. Further, it is not possible to meaningfully quantify a life saved or life prolonged. Therefore, any implementation proposal should incorporate a piloting exercise that considers the above barriers to implementation and makes explicit what the costs will be to overcome these.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A draft of this guideline was widely circulated to consumer groups, emergency departments, crisis mental health services, provider organisations, expert reviewers and clinicians for comment. It has been extensively modified to address the feedback received. Over 60 copies of the draft were circulated.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the Levels of Evidence (1++ to 4) and Grades of Recommendation (A to D, and Good Practice Points [GPP]) are given at the end of the Major Recommendations field.

Risk Factors

D Anyone who talks about suicide needs to be taken seriously. People who die by suicide have often expressed suicidal thoughts or displayed warning signs to families or health professionals.

GPP All people who report self-harm or suicidal intent should be treated as being in a state of potential emergency until clinicians are convinced otherwise.

Establishing a Therapeutic Alliance

GPP A key component to working with anyone who presents in a state of distress following a suicide attempt or expressing suicidal ideation is the conscious attempt to establish rapport with that person. This facilitates their disclosure of information and may serve as a protective factor by encouraging a sense of hopefulness and connectedness.

The Challenge of Working with People who Self-harm or Attempt Suicide

GPP All clinicians who work with people who self-harm or are suicidal should be in regular clinical supervision to mitigate the negative impact that this work can have both on them and on the quality of their work with suicidal people.

Involving Whanau/Family Support People of the Suicidal Person

GPP Whenever possible clinicians should involve whanau/family/support people/carers of the suicidal person when working with that person. This is equally true for the assessment component, crisis management, and subsequent treatment. At any time families can give information to the clinician without it compromising the person's privacy.

GPP If a person who is considered acutely suicidal declines involvement of others, the clinician may override that refusal in the interest of keeping the person safe.

Assessment of Suicide Risk

D Anyone who seeks assistance from an emergency department following an act of deliberate self-harm, irrespective of intent, or who is expressing suicidal ideation, should be further evaluated by a suitably trained mental health clinician.

GPP Culturally appropriate services should be involved with assessment, crisis management, and service liaison where possible, and if agreed to by the suicidal person.

GPP A suicide assessment should be conducted in a separate interview room that allows the person privacy when disclosing sensitive material.

GPP There is no evidence to suggest that directly asking about the presence of suicidal ideation or intent creates the risk of suicide in people who have not had suicidal thoughts or worsens the risk in those who have. It is more likely that a calm and matter-of-fact approach discussion of suicidality may allow people to disclose their previously "taboo" thoughts.

Assessment of Suicidality by Emergency Departments

Triage

GPP No person who has attempted deliberate self-harm or who is expressing suicidal ideation should be categorised to triage category 5 (i.e., waiting beyond one hour to be seen by a doctor).

General Assessment Principles

C Case notes should be augmented with structured assessments.

C Training in suicide assessments should be provided to all appropriate staff.

Medical Clearance

D Emergency department staff are encouraged to use the triage protocol described (see page 12 in the original guideline document) and the Rapid Assessment of Patients in Distress (RAPID) assessment tool (Appendix 1 in the original guideline document) to assess the urgency of need for mental health referral and security measures.

GPP Clinicians should maintain a high index of suspicion when a person arrives following an overdose. People will often under-report quantities consumed.

Sedation

C Acute sedation with medication may be necessary if the person shows violent or agitated behaviour or symptoms of psychosis. Consider prescribing an antipsychotic (such as haloperidol) or a short- to medium-term benzodiazepine (such as lorazepam which has a short half-life, or clonazepam which is presently the only intra-muscular benzodiazepine available). A full assessment must then be resumed.

A Haloperidol is contraindicated where the person is depressed or has central nervous system (CNS) depression due to drugs or alcohol.

GPP Haloperidol can cause painful dystonic reactions for some people, particularly among people who have never taken an antipsychotic before. In such cases, the co-prescription of an anticholinergic agent (such as benztropine) is advised. The newer antipsychotic medications have not yet been formally evaluated for use in this setting.

GPP Benzodiazepines should only be used for sedation as a short-term measure. They must be administered under supervision.

GPP Check for allergic reactions to some sedating drugs. Ask the person or obtain file notes.

GPP If a person has been sedated and then needs to be transported to another place for assessment, medical support must be provided during transit. The accompanying clinician needs to be aware of potential medical complications of sedation (e.g., respiratory arrest following intravenous benzodiazepine use).

Assessment of Intoxicated People

GPP People who present to emergency departments with suicidal ideation or following a suicide attempt whilst intoxicated should be provided with a safe environment until they are sober. Assessment should focus on their immediate risk (whilst they are still intoxicated). Enduring risk cannot be judged until the person is sober.

GPP People at risk of suicide should be strongly advised to stop using alcohol or illicit drugs due to their potential disinhibiting effects. Whanau/family members should also be told of this.

Referral to Mental Health Services

GPP Mental health services should at least be contacted (or existing management plan consulted) by the assessing emergency department clinician whenever suicidal ideation, intent, or a suicide attempt or self-harm is present.

Detailed Suicide Assessment/Assessment by Mental Health Services

Key Components of a Psychiatric/Psychosocial Assessment

B When conducting an assessment of suicide risk always be mindful of the presence of concomitant mental illness, particularly the following diagnoses, which are associated with increased risk.

- Major depression - acute risk factors: severe anhedonia, insomnia, anxiety, substance abuse.
- Substance abuse - acute risk factors: comorbid depression, recent interpersonal loss or disruption.

- Schizophrenia - acute risk factors: age <40, chronicity of illness with frequent exacerbations, awareness of deterioration and poor prognosis, depression.
- Borderline Personality Disorder or Antisocial Personality Disorder - acute risk factors: comorbid Axis I disorders, particularly depression.

Use of Screening Measures

B The Beck Hopelessness Scale has the best generic application for screening for suicide risk amongst adults, adolescents, inpatients, outpatients, and people seeking assistance from emergency departments.

Formulating Risk

GPP Mental state and suicidal ideation can fluctuate considerably over time. Any person at risk should be re-assessed regularly, particularly if their circumstances have changed.

Crisis/ Initial Management

D The presence of a "safety contract" does not in any way guarantee the person's actual safety. There is no evidence that it acts as a deterrent to suicide.

Management as an Outpatient

A Providing people with "green cards" (24-hour access to a crisis team) is a useful but insufficient treatment strategy, and other interventions should also be provided.

The Decision to Hospitalise

D The following people with suicidal ideation should be admitted when:

- they are acutely suicidal
- medical management of an attempt is required
- they require more intensive psychiatric management
- the establishment of a treatment alliance and crisis intervention fails and the person remains acutely suicidal

D When no suitable caregivers/support people are available, respite care options may be considered as an alternative to admission.

A In order to reduce the person's risk of suicide, admission should be for more than 4 days.

C For a chronically suicidal person short admissions (1- 4 days) may be appropriate.

GPP If the person is not admitted, appropriate arrangements must be made for timely follow-up with the relevant health provider (e.g., care manager, therapist) within 24 hours.

GPP The reasons for not admitting must be clearly documented in the person's file.

Management as an Inpatient

GPP People assessed as being at high risk of suicide should be under close supervision. (See Appendix 6 in the original guideline for guidelines for supervision.)

GPP The level of support and observation should reflect the person's changing suicide risk.

C Inpatient unit staff need to be vigilant, particularly when the person is not well-known and for the first week after admission.

D Treatment (both psychopharmacological and psychological) of underlying mental illnesses should be initiated as early as possible.

Discharge Planning

A Follow-up should occur in the first week post-discharge, as this is the highest risk time for a person discharged from hospital. This should happen even if the person fails to attend their outpatient appointment.

D If the person does not attend their follow-up appointment and is believed to still have a significant risk of suicide, the clinician must make efforts to contact that person immediately to assess their risk of suicide or self-harm.

GPP The discharge plan should be developed in consultation with the person and their key support people (including whanau/family if appropriate) and clinicians.

GPP Before leaving the hospital the person should have a clear understanding of discharge arrangements that have been made and a written copy with information about medication, treatment plans, and key contacts to call, if needed.

GPP If appropriate, the person's whanau/family or nominated next-of-kin should be informed of the person's risk, told of their next appointment, and invited to attend. They should also be involved in discharge planning processes.

GPP The continuing care provider/team must get at least a verbal report prior to discharge. They should also be included in any discharge planning meetings/decision-making processes.

GPP The person's general practitioner should also get a full copy of the discharge plan, including any medication recommendations. If the general practitioner is the sole care provider, he/she should receive this prior to the person's discharge from hospital.

Intervention/Treatment Strategies

A Follow-up by the same therapist across inpatient and outpatient settings results in people at risk of suicide being more likely to agree to take medication and to attend appointments.

Prescribing Issues

C Clinicians should be cautious when prescribing benzodiazepines (both acutely and in the medium-term), especially if the person may also be suffering from depression or have risk factors for suicide.

C Clinicians need to monitor suicide risk closely irrespective of the antidepressant/drug used. This is essential both to rule out any paradoxical increase in suicidality and also to ensure that risk does not increase as the treatment begins to work, relieving the motor symptoms and lack of drive first, but not the mood related symptoms.

GPP In general, if a person is suspected of being at risk of suicide, appropriate medications should be prescribed and dispensed in dosages and quantities that are less likely to be lethal in overdose or in combination with other drugs or alcohol.

Assessment and Crisis Management with Special Populations

Children and Adolescents

D The assessment of suicidal young people should be carried out by a clinician who is skilled in interviewing and working with children and adolescents whenever possible.

D Self-harm among children is rare and should be treated very seriously.

GPP Risk assessments should draw on information from multiple sources, including the young person, their teachers/guidance counselors, parents etc.

The Elderly

GPP Any elderly person who is expressing suicidal ideation or has presented following an attempt should be treated very seriously. The clinician should consider whether the symptoms could be related to self-neglect or reflect a passive death wish.

GPP Clinicians should treat symptoms of depression in an older person assertively. If depression and/or suicidality is suspected, physical causal factors need to be ruled out.

GPP Assessments should also draw on information from relatives or friends who can comment on whether the person is different from "their usual self."

Maori

GPP Assessment of Maori people requires consideration of their cultural context and meaning associated with their identity as Maori. Specialist Maori input is important when cultural issues or issues of identity arise among tangata whaiora. Maori people who are suicidal should be offered the input of specialist Maori mental health workers.

GPP People's preference should be sought and respected for involving whanau or support of others in assessment and developing a treatment/management plan.

Pacific Peoples

GPP Assessment of Pacific peoples requires consideration of their Pacific cultural contexts and beliefs. Specialist Pacific input is important when cultural issues or issues of breaches of protocol are present among Pacific peoples. Pacific peoples who are suicidal should be offered the input of specialist Pacific mental health workers.

GPP Pacific peoples' preference should be sought and respected for involving family or support of others (e.g., church leaders, traditional healers) in assessment and developing a treatment/management plan.

GPP Language barriers may be an issue for some Pacific peoples. Care must be taken in ensuring confidentiality when interpreters are used due to the small size of Pacific communities and the shame associated with suicide and attempted suicide among Pacific peoples.

People of Indian Descent

GPP Indian people come from many diverse cultures, and assessment should acknowledge their specific cultural contexts and beliefs.

GPP Indian people consider family roles and obligations of primary importance, and assessment should acknowledge their needs within the context of their family.

GPP Problem-solving, psycho-education, and the use of trusted intermediaries can help counter some of the shame or "loss of face" associated with mental illness.

Asian Populations

GPP Cultural values and beliefs vary depending on the person's subculture and degree of acculturation to Western values. Even if the person identifies themselves as a New Zealander, it is still important to check the cultural values of their family and significant others, as a gap in views can be a source of stress.

GPP Language barriers may be an issue for some Asian people. Care must be taken in ensuring confidentiality when interpreters are used due to the small size of Asian communities.

GPP When working with someone from an Asian community the clinician should consult culturally appropriate services to assist in intervening in helpful ways.

Refugee Groups

GPP Refugees are most likely to have been victims of some level of trauma. They may be distrustful of official agencies and health systems. Clinicians need to proceed respectfully and carefully, explaining the intention behind any action and potential consequences for the person. Clinicians should not push for accounts of past trauma experiences, and may need to focus more on the "here and now."

GPP If an interpreter is needed, care must be taken over confidentiality issues as many of the communities are small and people may know each other.

GPP Serious consideration should be given to referring refugees with mental health difficulties to specialist agencies such as Refugees as Survivors.

Assessment and Management of Chronically Suicidal People

C Detailed management plans that list both chronic and acute symptoms should be developed with the person. This assists clinicians in determining whether a person is presenting with new/greater risk than their ongoing risk. All services working with this person should have a copy of these plans, and they should be regularly reviewed and updated.

C Emergency departments should always contact mental health services (even if only by phone) when a chronically suicidal person presents. Care must be taken not to downplay the seriousness of attempts.

D When a person who is well-known to the service arrives at the emergency department, it is crucial that their file is obtained, their management plan consulted, and ideally their case manager or therapist contacted in case they are now suffering from additional stressors or a significant change in their mental illness(es).

D Inpatient admission or referral to high support services (such as crisis respite) may be necessary when the person's suicidality is exacerbated by an acute life stressor, or if they also develop an Axis I disorder.

Definitions:

Levels of Evidence

1++

High quality meta-analyses/systematic reviews of randomised controlled clinical trials (RCTs), or RCTs with a very low risk of bias

1+

Well-conducted meta-analyses/systematic reviews, or RCTs with a low risk of bias

1-

Meta-analyses/systematic reviews, or RCTs with a high risk of bias

2++

High quality systematic reviews of case-control or cohort studies

High quality case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+

Well-conducted case-control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-

Case-control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3

Non-analytic studies (e.g., case reports). Case series

4

Expert opinion

Qualitative material was systematically appraised for quality, but was not ascribed a level of evidence.

Grades of Recommendations

A

At least one meta-analysis, systematic review, or randomised, controlled clinical trial (RCT) rated 1++ and directly applicable to the target population

or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B

A body of evidence consisting principally of studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results

or

Extrapolated evidence from studies rated as 1++, or 1+

C

A body of evidence consisting principally of studies rated as 2+, directly applicable to the target population, and demonstrating overall consistency of results

or

Extrapolated evidence from studies rated as 2++

D

Evidence level 3 or 4

or

Extrapolated evidence from studies rated as 2+

Additionally, Good Practice Points are recommended as the best practice based on the clinical experience of the guideline development team.

CLINICAL ALGORITHM(S)

A clinical algorithm on "The Assessment and Management of People at Risk of Suicide" is provided as a companion to the original guideline document.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The advice on the assessment and management of people at risk of suicide given in this guideline is based on epidemiological and other research evidence, supplemented where necessary by the consensus opinion of the expert development team based on their own experience.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management and intervention with people who have made a suicide attempt with the intent (or partial intent) of ending their lives and those who are at risk of taking their own lives

POTENTIAL HARMS

- Haloperidol should only be used for sedation if the person shows violent or agitated behaviour or symptoms of psychosis.
- There may be some link between suicide risk and benzodiazepine use. Benzodiazepine use may worsen an underlying depression or cause a person to become disinhibited and therefore more likely to act impulsively. However, they do have some use in treating severe agitation and anxiety, which may outweigh these risks.

CONTRAINDICATIONS

CONTRAINDICATIONS

Haloperidol is contraindicated where the person is depressed or has central nervous system (CNS) depression due to drugs or alcohol.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

While the guidelines represent a statement of best practice based on the latest available evidence (at the time of publishing), they are not intended to replace the health professional's judgment in each individual case.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Gaps and Barriers to Implementation

Key gaps relevant to the implementation of these suicide prevention guidelines include the following:

1. Access to services: access can be difficult for people in rural settings. It is also limited for Maori and Pacific peoples wanting culturally specific crisis services. Specific gaps also exist in crisis services for children, youth, and older people. Facilities may be unwelcoming and unhelpful for people in a state of extreme distress, such as the waiting rooms of some emergency departments. General impressions suggest that clinicians also have difficulty accessing crisis management resources such as crisis respite and inpatient beds on behalf of their clients.
2. Crisis service integration/delivery: there was evidence of poor coordination and lack of cooperation between crisis services, emergency departments, and other mental health services. Also evident were breakdowns in liaison between services, often with parties having poor understanding of the services that each offered. Nearly 20% of the services did not have policies or protocols in place in regard to risk assessment.
3. Response times: after-hours services were characterised by long response times, lack of staff, and a lack of available medical cover in some areas.

4. Difficulties managing intoxicated people – there is limited recognition by some crisis workers of the potentially serious risks for people in a state of intoxication.

Clinician Barriers

Gaps in best practice identified in the Mental Health Commission´s (MHC) review of crisis services indicated that there are a lack of crisis training opportunities, a lack of widely agreed and implemented competencies for crisis workers, and a lack of systems and processes for supervision and external clinical review.

People working with suicidal people have a range of backgrounds and training. Even in crisis teams there is a wide variation in training and expertise. In the review conducted by the MHC (2001), five areas reported not having access to medical back-up and no routine review of crisis work with medical staff.

A key effort in any implementation process must be to target clinician knowledge and attitudinal change, particularly promoting staff members´ confidence in assessing and managing risk, so fewer people at risk are overlooked due to fears about asking about suicide. There is a common perception that asking about suicide increases the risk of suicide, by planting the idea in distressed but previously not suicidal individuals, but there is no evidence to support this.

Key Implementation Issues

The key focus of implementing the guidelines should be on up-skilling the workforce to better assess and manage suicidal risk and reviewing work force configuration to better respond to risk, in accordance with the evidence-based guidelines. The key elements to implementing these guidelines are fourfold.

1. To target implementation strategies to affect individual clinicians´ practice
2. To target implementation strategies to address clinical process issues (e.g., who does risk assessments? what are the referral paths and processes? how is data collected?)
3. To target implementation strategies at a service configuration level (e.g., how do the services interface? what are the lines of clinical accountability?) This may have implications for resources or how existing services are configured.
4. To ensure the above three components are done in accordance with key recommendations of the guidelines and evidence for effective practice

Auditing the Guidelines

The overarching aim of these guidelines is to reduce the number of suicides by people who are currently, or have recently been, in contact with mental health services and/or emergency departments. An integral part of implementing these guidelines is the auditing process. The guideline development team recommends that the Ministry of Health should develop an auditing procedure, which could include the following assessment measures.

1. Mental health services should be asked to adopt a checklist to ensure that:

- all staff have training in the management of risk as part of their core competency requirements
- all people identified as at risk will have individual risk-management plans that also specify action to be taken if the person does not attend appointments
- there is prompt access to services for people in crisis and their families
- there is prompt follow-up for everyone discharged from hospital with serious mental illness or a history of recent self-harm or a suicide attempt

2. Emergency departments should be asked to adopt a checklist to ensure that:
    - all staff have training in the assessment of risk and triage for suicidal people as part of their core competency requirements
    - all staff have training in crisis management and appropriate referral
3. Procedural issues should be addressed, including the use of critical incident reviews when people have attempted suicide (e.g., in the ward or whilst a client of mental health services) to establish what might have been done differently. The interface between services should also be monitored. This process should facilitate problem resolution rather than contribute to a culture of blame.

IMPLEMENTATION TOOLS

Clinical Algorithm
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New Zealand Guidelines Group (NZGG). The assessment and management of people at risk of suicide. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 May. 72 p. [89 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 May

GUIDELINE DEVELOPER(S)

New Zealand Guidelines Group - Private Nonprofit Organization

SOURCE(S) OF FUNDING

Ministry of Health

GUIDELINE COMMITTEE

Guideline Development Team

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Team Members: Pete Ellis (Chair), Consultant Psychiatrist, Head of Department of Psychological Medicine, Wellington School of Medicine and Health Sciences, University of Otago, Wellington; Ian Goodwin, Consultant Psychiatrist, Mason Clinic (Forensic Services), Auckland; Brian Craig, Consultant, Child and Adolescent Psychiatrist/Clinical Director, Canterbury District Health Board (DHB), Christchurch; Suzy Stevens, Vice Chairperson, Council for Mental Well-Being Trust, Auckland; Henriette Fleischer, Associate Committee Member, Schizophrenia Fellowship New Zealand, Christchurch; Annette Beautrais, Principal Investigator, Canterbury Suicide Project, Christchurch School of Medicine and Health Sciences, University of Otago, Christchurch; Shameem Safih, Emergency Physician, Clinical Director, Emergency Department, Waikato Hospital, Hamilton; Laurie-Jo Moore, Service Clinical Director and Consultant Psychiatrist, Rodney District of Waitemata Health, Auckland; Janet Farquharson, Psychiatric District Nurse, Otago District Health Board, Dunedin; Julia Mitchell, Registered Comprehensive Nurse, Wellington Emergency Department, Wellington; Emma Sutich, Senior Clinical Psychologist, Project Manager, NZGG, Wellington

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Declaration of Competing Interests

Pete Ellis has accepted support from Janssen-Cilag to attend a recurring scientific meeting in New Zealand as a presenter and part organiser.

Brian Craig has received travel support to attend an overseas conference from Janssen-Cilag.

ENDORSER(S)

Australasian College for Emergency Medicine - Medical Specialty Society
Council for Mental Well-Being Trust - Professional Association
Mental Health Commission (NZ) - Disease Specific Society
NZNO Mental Health Nurses Section - Professional Association
Royal Australian and New Zealand College of Psychiatrists - Professional Association

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.

Print copies: Available from the New Zealand Guidelines Group Inc., Level 30, Grand Plimmer Towers, 2-6 Gilmer Terrace, PO Box 10-665, Wellington, New Zealand; Tel: 64 4 471 4188; Fax: 64 4 471 4185; e-mail: info@nzgg.org.nz.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- New Zealand Guidelines Group (NZGG). Summary guideline for emergency departments. The assessment and management of people at risk of suicide. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 May 4 p. Available from in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.
- New Zealand Guidelines Group (NZGG). Mental health service acute assessment settings: quick reference. The assessment and management of people at risk of suicide. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 May 1 p. Available from in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.
- New Zealand Guidelines Group (NZGG). Rapid assessment of patients in distress. The assessment and management of people at risk of suicide. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 May 2 p. Available from in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.
- New Zealand Guidelines Group (NZGG). Search strategy. The assessment and management of people at risk of suicide. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 May 2 p. Available from in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.

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PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on June 17, 2004. The information was verified by the guideline developer on July 19, 2004.

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